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FILED OCT 23 1948
Registration District No. 2

Primary Registration District No. 6026

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Gouldsworth Convalescent Home
(If not in hospital or institution, write street number or location)
8950 Manchester Ave.
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Lela Laughlin
3. (b) If veteran, name war
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Milton Laughlin
6. (c) Age of husband or wife if alive, years
7. Birth date of deceased October 10 1861
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
86 11 16 hr. min.

9. Birthplace Germany Germany
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Unknown

12. Name Unknown
13. Birthplace Germany
(City, town, or county) (State or foreign country)

14. Maiden name Unknown
15. Birthplace Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ray Laughlin
(b) Address 5033 Emerson Ave.

17. (a) Burial (b) Date thereof 9/29/48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Stroott-Carroll
(b) Address 4600 Natural Bridge Ave.

19. (a) 9-27-48 (b) Paula J. Stroott
(Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis
(c) City or town Manchester
(If outside city or town limits, write "RURAL")
(d) Street No. 8950 Manchester Rd.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept. day 26
year 1948 hour 1 minute 45 P. M.
21. I hereby certify that I attended the deceased from June
1947 to Sept 26 1948
that I last saw her alive on 9/25/48
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute Cardiac Dilatation
Due to Chronic Myocarditis
93d

Other conditions (Include pregnancy within 6 months of death)
Major findings:
Of operations
Of autopsy
PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work (Specify type of place) (e) Means of injury
23. Signature Paula J. Stroott (M. D. or other)
Address Kirkwood, Mo. Date signed 9/27/48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. non

Registration District No. 317

Primary Registration District No. 6076

Registrar's No. 2240-

1. PLACE OF DEATH:

- (a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution. (Specify whether

In this community _____ years, months or days)

3. (a) PRINT FULL NAME

Tela Laughlin

3. (b) If veteran,

name war _____

3. (c) Social Security

No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced and

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____

7. Birth date of deceased 6 Oct 10

(Month)

(Day)

(Year)

8. AGE:

Years 86

Months 11

Days 1

If less than one day

hr. _____ min. _____

9. Birthplace

(City, town, or county)

(State or foreign country) Germany

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

- (b) Address

17. (a) _____ (b) Date thereof

(Burial, cremation, or removal)

(Month) (Day) (Year)

- (c) Place: burial or cremation

18. (a) Signature of funeral director

- (b) Address

19. (a) _____
(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

- (c) City or town _____
(If outside city or town limits, write "RURAL")

- (d) Street No. _____
(If rural, give location)

- (e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1948 year 1948 hour _____ minute _____ M. _____

21. I hereby certify that I attended the deceased from _____

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

Due to _____

Due to _____

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) _____

- (b) Date of occurrence _____

- (c) Where did injury occur? _____ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

S-35148